Using Outcomes Information for Revalidation in Urology

December 2013

The Colleges and Surgical Specialty Associations believe that data on surgical outcomes is an important element of demonstrating that a surgeon meets the required standards of professionalism and practice. This framework provides guidance to surgeons working in urology to help them produce relevant outcomes data for appraisal and revalidation.

Any queries relating to this framework should be addressed to revalidation@rcseng.ac.uk.

Section 1: Introduction and Explanation

Background

Revalidation is the new approach to the regulation of doctors, it commenced in December 2012. The process is centred on local annual appraisal. All doctors will need to be revalidated every 5 years in order to retain their licence to practise.

The Surgical Specialty Associations and Surgical Royal Colleges have developed the standards for surgical revalidation and specified the supporting information that urologists will need to provide to their appraiser to facilitate a positive assurance of their fitness to practice and, at the end of the 5 year cycle, a recommendation for revalidation to the GMC. An important component of the supporting information required for revalidation is that relating to outcomes.

An important landmark in relation to transparency and openness in the NHS was achieved in 2013 with the publication of surgeon-level data from nine surgical audits. We see national clinical audit as the "gold standard" in relation to collection of data and measurement of outcome. We fully support the continuation and expansion of NHS England's programme of data transparency.

The British Association of Urological Surgeons has defined the following measures for surgeons working within the specialty. Surgeons will only need to demonstrate their outcomes in their area(s) of practice. There is no requirement for urologists to undertake common 'index procedures'.

You should note the following points:

National Clinical Audit

- Where there are identified national clinical audit(s) that cover your area(s) of practice, it is essential that you participate. This will be mandatory for revalidation.
- If there is a national clinical audit that falls within NHS England's programme of consultant-level outcomes publication, your results will be made available publically.
- Your employer will need to facilitate the submission of data to the audit(s).
- It will be your responsibility to gather the relevant information from the audit (eg. reports/downloads) to present at appraisal.

Routinely Collected Data (HES, PEDW, HIS, ISD)

- These data are already collected by your NHS organisation and brought together on a national basis.
- We have identified key procedures in each sub-specialty area which should cover the majority of surgeons' practice.
- We have identified what should be measured and how.
- We expect that analyses of these data will be provided by your employer.
- Wherever possible your individual outcomes should be presented alongside all other surgeons in the country performing that procedure(s) (eg. in a funnel plot).
- We have identified the process of further investigation if it appears from these analyses that your outcomes are outside accepted norms (see below).

Local Audit

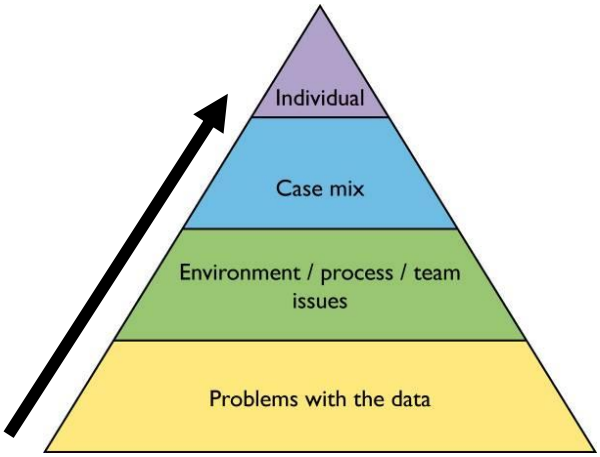
- Where your area of practice is not appropriately covered by a national audit or where routinely collected data will not assist in measuring outcomes, we recommend some form of local audit.
- This may be conducted by you personally, or form part of a wider unit/region-based audit.
- It will be your responsibility to conduct/participate in the audit and present the results at appraisal.
- Where you are obliged to undertake local audit, you are advised to audit a practice or procedure that is representative of your practice both in the NHS and in the private sector. The subject should be something that you undertake on a routine basis.

Structured Peer Review (of outcomes)

- For some highly specialised/low volume areas of practice which cannot be appropriately measured using the above methods, it may be necessary to have some form of structured peer review. Where this is identified as necessary, we will work with the relevant specialties to identify the methodology required so that the peer review process is fit for purpose for revalidation.

Managing Outliers

- Analysis of your outcomes provides one piece of the supporting information required for revalidation.
- If it appears that your outcomes are outside of the accepted norm, this should trigger a local investigation that closely examines the data for anomalies, looks at the environment and structure of the team/unit and your case mix before considering you as an individual (see diagram 1).
- We will be able to assist in the early stages of such an investigation.


Individual
Case mix
Environment / process / team issues
Problems with the data
Diagram 1

Section 2 Measuring Outcomes

2.1 General urology

2.2 Sub-specialist Urological Practice:
- 2.2.1 Oncology – Pelvic
  Oncology – Upper tract
- 2.2.2 Female Urology
- 2.2.3 Reconstructive Urology
- 2.2.4 Endourology
- 2.2.5 Andrology

2.3 General Paediatric Urology

2.1 General Urology

1. Most Urologists will have a significant proportion of General Urology in their regular practice. Outcomes from these procedures should be measured by looking at **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s). Surgeons should also present evidence of attendance at MDT meetings. The previous year's performance should be examined preferably against performance over the previous 5 years.

Key Procedure(s)	Codes	Generic Outcome Measures
Hydrocele	N11	- Length of Stay (day case rate AND median) - 28 day unplanned readmission - 28 day re-operation/reintervention - Discharge destination
TURP	M67	
TURBT	M42	

2.2 Sub-specialist Urological Surgery

1. The main method of outcome measurement will be **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s).

2. It is expected that the sub-specialty surgeon will select either the top three most commonly performed procedures or 3 index procedures for performance analysis, together with evidence of attendance at MDT meetings and participation in the relevant national clinical audit/registry for their appraisal. If no national audit is available then conduct a local audit of their practice at least once per 5 year revalidation cycle.

2.2.1 Pelvic Uro-Oncology

1. As many oncologists have become single disease surgeons, urologists should select their 3 index procedures. Outcomes from these procedures should be measured by looking at **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s). Surgeons should also present evidence of attendance at MDT meetings. The previous year's performance should be examined preferably against performance over the previous 5 years.

Key Procedure(s)	Codes	Generic Outcome Measures
Radical Cysto-prostatectomy	M34.1 - Open M34.1 + Y75.2 (Lap) M34.1 + Y75.3 (robotic)	Length of stay (day case AND median) 30 day mortality 28 day re-operation/reintervention 28 day unplanned re-admission
Construction of Ileal Conduit	M119.1	
Radical Cystoprostato-urethrectomy	M34.1	
Radical cystectomy – female	M34.3	
Radical Prostatectomy	M61.1 – Open + Y76.5 (Lap) +Y75.2 (robot)	
Radical Prostatectomy + Nodes	M6180	
Total urethrectomy	M7200	

2. In addition, you will need to participate in the relevant BAUS audit:
   - Complex procedures
   - Cancer registry

3. Where there is no national audit which covers the procedures you have selected, you will need to perform one local audit per 5 year revalidation cycle.

2.2.2 Upper Tract Oncology:

1. Urologists should select their top 3 most common procedures. Outcomes from these procedures should be measured by looking at **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s). The previous year's performance should be examined preferably against performance over the previous 5 years. Surgeons should also present evidence of attendance at MDT meetings.

Key Procedure(s)	Codes	Generic Outcome Measures
Radical Nephrouretectomy	M0220	Length of stay (day case AND median) 30 day mortality 28 day re-operation/reintervention 28 day unplanned re-admission
Radical Nephrectomy	M02.1 +y75.2 (Lap)	
Partial Nephrectomy	M03.9	
RPLND for advanced testis cancer **	T85	

2. In addition, you will need to participate in the relevant BAUS national audits:
   - BAUS cancer registry
   - BAUS nephrectomy audit

** Surgeons performing RPLND for advanced testis cancer may not find analyses of HES data useful as these procedures are low volume. We therefore suggest local audit and, if necessary, structured peer review of practice.

2.2.3 Female Urology & Reconstruction:

1. Urologists should select their top 3 most common procedures. Outcomes from these procedures should be measured by looking at **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s). The previous year's performance should be examined preferably against performance over the previous 5 years. Surgeons should also present evidence of attendance at MDT meetings.

Key Procedure(s)	Codes	Generic Outcome Measures
Ileal bladder replacement Implant artificial sphincter Urinary diversion: Ileal conduit Ureteric reconstruction	M2130 M5520 M1910 M2100	Length of stay (day case AND median) 30 day mortality 28 day re-operation/reintervention 28 day unplanned re-admission
Urethroplasty: • Anastomotic • BM Graft • Complex	M7360 – simple M7361 - complex	Length of stay (day case AND median) 28 day re-operation/reintervention 28 day unplanned re-admission
Colpo-suspension	M52	
Urethral Sling Procedure	M53	
Pelvic floor repair	P23, M55	
Repair urethro-vaginal fistula	M3780	
Intravesical BOTOX	M44	28 day unplanned re-admission

2. In addition to routinely collected data analyses, surgeons must submit data to the national annual audits organised by the Section of Female and Functional Urology.

3. If your selected procedures are not subject to national audit, you will need to perform one local audit per 5 year revalidation cycle.

2.2.4 Endourology

1. Urologists should select their top 3 most common procedures. Outcomes from these procedures should be measured by looking at **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s). The previous year's performance should be examined preferably against performance over the previous 5 years. Surgeons should also present evidence of attendance at MDT meetings.

Key Procedure(s)	Codes	Generic Outcome Measures
Adrenalectomy	B22	Length of stay (day case AND median) 28 day re-operation/reintervention 28 day unplanned re-admission
Diagnostic Ureteroscopy Ureteroscopic treatment of ureteric stone	M3000 M2730	
PCNL (percutaneous renal stone surgery)	M0940	
Anderson-Hynes Pyeloplasty	M1080 (Lap) M0510 (Open)	
Simple Nephrectomy	M0250 + Y75.2 (Lap)	Length of stay (day case AND median) 30 day mortality 28 day re-operation/reintervention 28 day unplanned re-admission

2. In addition to routinely collected data analyses, surgeons must submit data to national audit:
   - BAUS cancer registry
   - BAUS nephrectomy audit
   - Evidence of submission to BAUS Section of Endourology Annual Audits

3. If your selected procedures are not subject to national audit, you will need to perform one local audit per 5 year revalidation cycle.

2.2.5 Andrology

4. Urologists should select their top 3 most common procedures. Outcomes from these procedures should be measured by looking at **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s). The previous year's performance should be examined preferably against performance over the previous 5 years. Surgeons should also present evidence of attendance at MDT meetings.

Key Procedure(s)	Codes	Generic Outcome Measures
Correction of penile curvature: Nesbitt Lue Penile Implant surgery Penile Cancer surgery	N2780 Different codes according to procedure: N2710 N2620 N2610	Length of stay (day case AND median) 28 day re-operation/reintervention 28 day unplanned re-admission

5. In addition to routinely collected data analyses, surgeons must submit data to national audit.

6. Surgeons performing specialised procedures (eg. phalloplasty) may not find analyses of HES data useful as these procedures are low volume. We therefore suggest local audit and, if necessary, structured peer review of practice.

2.2.6 General Paediatric Urology

1. Urologists should select their top 3 most common procedures. Outcomes from these procedures should be measured by looking at **routinely collected data** (HES, PEDW, HIS, ISD) against the criteria set out in this document. At appraisal we would expect that a surgeon's outcomes would be presented in a funnel plot showing comparison of their practice to all other surgeons in the country performing the same procedure(s). The previous year's performance should be examined preferably against performance over the previous 5 years. Surgeons should also present evidence of attendance at MDT meetings.

Key Procedure(s)	Codes	Generic Outcome Measures
Hypospadias repair: Orchidopexy Herniotomy Circumcision	M7314 N08 T19 N3030	Length of stay (day case AND median) 28 day re-operation/reintervention 28 day unplanned re-admission